Patient Registration Form

Patient's Last Name _____ First_____ MI _____
Mailing Address_____ _____City_____
State_____Zip_____
Home Phone _____ Work Phone _____
Cell Phone _____ Email_____

Male ____ Female ____ Date of Birth_____ SS# _____
Occupation _____ Employer _____

INSURANCE INFORMATION:
Name of Insured Person _____ SS# _____
Insured's Date of Birth _____ Employer's Name
_____
Employer's Phone _____
Insurance Name _____ Insurance Phone
_____
Group # _____

METHOD OF PAYMENT:
Person responsible for account _____ Phone _____
Check____ Cash____ Credit/Debit Card____ Wells Fargo_____Care Credit_____

In Case of Emergency, please contact:
_____
Home phone _____ Work phone _____ Cell Phone _____

Whom may we thank for referring you to us? _____

I understand that my insurance company may pay less than the actual bill for services and that I am fully responsible for payment of my account. By signing this statement I agree to pay for all balances not paid by my insurance company and any legal fees incurred to enforce this statement.

I hereby authorize the release of any information relating to insurance claims and I authorize payment of my group insurance benefits directly to Meadowlark Dental Associates P.C.

I certify that the information I have provided here is true and correct.

Signature _____ Date _____